



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

LEAH KAPEEN
CITY VIEW ADULT FAMILY HOME
535 SW City View St
Pullman, WA 99163

RE: CITY VIEW ADULT FAMILY HOME License # 750767

Dear Provider:

This letter addresses Compliance Determination(s) 82705 (Completion Date 08/24/2026) and 77618 (Completion Date 07/08/2026).

The Department completed a follow-up inspection of your Adult Family Home on 08/24/2026 and found that you have corrected the violations listed in the Complaint report dated 07/08/2026. Your home is back in compliance as of 08/21/2026 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10390-1-a, WAC 388-76-10390-2-a

The Department staff who did the on-site verification:
Lori Butler, AFH Complaint Investigator/Licensors

If you have any questions, please contact me at (509)598-0182.

Sincerely,

Selena Clemons

Selena Clemons, Interim Community Field Manager
Region 1, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 750767	Compliance Determination #77618
Plan of Correction	CITY VIEW ADULT FAMILY HOME	Completion Date
Page 1 of 7	Licensee: LEAH KAPEEN	07/08/2026

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 05/19/2026 and 06/08/2026 of:

CITY VIEW ADULT FAMILY HOME
535 SW City View St
Pullman, WA 99163

This document references the following complaint number(s): 220869, 226500

The following sample was selected for review during the unannounced on-site visit: 3 of 6 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Lori Butler, AFH Complaint Investigator/Licensors

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1, Unit E
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

This document was prepared by Residential Care Services for the Locator website.

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Selena Clemons

Residential Care Services

07/15/2026

Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.



Provider (or Representative)

7/24/26

Date

WAC 389-76-10390 Admission and continuation of services. The adult family home must only admit or continue to provide services to a person when:

- (1) The home can safely and appropriately meet the assessed needs and preferences of the person:
 - (a) With available staff; and
- (2) Admitting the resident does not negatively affect the ability of the home to:
 - (a) Meet the needs and does not endanger the safety of other residents; or

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the AFH could safely and appropriately meet the needs of 5 of 6 residents (Residents 2, 3, 4, 5, & 6) when the AFH continued to provide care to Resident 1 whose behavioral needs could not be safely met with available staff. This failure resulted in Resident 2 being physically assaulted by Resident 1 and placed other residents at risk for harm.

Findings included...

On 06/08/2026 at 12:00 PM observation showed Resident 1 lived in the home, had been outside with another resident and was unsupervised by staff.

Review of Resident 2's admission agreement dated 10/02/2022 showed Resident 2 had the right to receive care in a safe, clean, comfortable and homelike environment.

This document was prepared by Residential Care Services for the Locator website.

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Selena Clemons

Residential Care Services

07/15/2026

Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

Date

WAC 388-76-10390 Admission and continuation of services. The adult family home must only admit or continue to provide services to a person when:

- (1) The home can safely and appropriately meet the assessed needs and preferences of the person:
 - (a) With available staff; and
 - (2) Admitting the resident does not negatively affect the ability of the home to:
 - (a) Meet the needs and does not endanger the safety of other residents; or

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the AFH could safely and appropriately meet the needs of 5 of 6 residents (Residents 2, 3, 4, 5, & 6) when the AFH continued to provide care to Resident 1 whose behavioral needs could not be safely met with available staff. This failure resulted in Resident 2 being physically assaulted by Resident 1 and placed other residents at risk for harm.

Findings included...

On 06/08/2026 at 12:50 PM observation showed Resident 1 lived in the home, had been outside with another resident and was unsupervised by staff.

Review of Resident 2's admission agreement dated 10/02/2022 showed Resident 2 had the right to receive care in a safe, clean, comfortable and homelike environment.

Review of Resident 3's admission agreement dated 07/26/2023 showed Resident 3 had the right to receive care in a safe, clean, comfortable and homelike environment.

Review of Resident 4's admission agreement dated 03/04/2020 showed Resident 4 had the right to receive care in a safe, clean, comfortable and homelike environment.

Review of Resident 5's admission agreement dated 07/05/2023 showed Resident 5 had the right to receive care in a safe, clean, comfortable and homelike environment.

Review of Resident 6's admission agreement dated 04/24/2020 showed Resident 6 had the right to receive care in a safe, clean, comfortable and homelike environment.

Review of Resident 1's admission agreement dated 03/12/2024 showed the facility would not transfer or discharge a resident against their will unless transfer or discharge was necessary for the Resident's welfare and the Resident's needs could not be met by the facility or the safety of individuals in the facility is endangered.

Review of Resident 1's assessment dated 01/16/2026 showed Resident 1 had diagnosis of

[REDACTED] and [REDACTED] and behaviors of being assaultive, destructive, verbally abusive and threatening behaviors, had threatened people in the home with sharp objects, had bitten another resident in the home, had thrown and broken items, had verbally abused and threatened to harm other residents and care staff and should be kept in staffs' line of sight at all times for safety.

Review of Resident 1's Negotiated Care Plan dated 03/09/2026 showed Resident 1 had erratic and volatile behaviors, suicidal ideation, refusal to consider use of mental health medication, self-harm, physical assault and threats on others and themselves. The NCP dictated that the home provide twenty-four hour a day one-to-one staff supervision and care in order to keep both Resident 1 and the residents in the home safe.

Review of Resident 2's Current Annual Assessment completed on 07/23/2025 and Negotiated Care Plan (NCP) signed on 10/30/2025 showed the resident was a [REDACTED] [REDACTED] was non-weight bearing, wheelchair bound, had a history of falls, general weakness, and limited range of motion which required extensive, one to two-person physical assistance.

Review of Resident 3's Current Annual Assessment completed on 11/19/2025 showed the resident had diagnosis of [REDACTED]

[REDACTED]
[REDACTED] had left sided weakness, limited range of motion, poor balance and an unsteady gait which required supervision and one-person physical assistance at times.

Review of Resident 4's Current Annual Assessment completed on 04/20/2026 showed the resident had diagnosis of [REDACTED]

[REDACTED] and [REDACTED]

[REDACTED] and was bedfast or chairfast, unable to feed themselves, had general weakness, limited range of motion, partial weight bearing, poor balance, tremors, unsteady gait, weak grip and limited fine motor control which required extensive, one to two-person physical assistance.

Review of Resident 5's Current Annual Assessment completed on 03/26/2026 showed the resident had diagnosis of [REDACTED]

[REDACTED] and required supervision, redirection, and medication management.

Review of Resident 6's Current Annual Assessment completed on 12/19/2025 showed the resident had diagnosis of [REDACTED]

[REDACTED] had general weakness, poor balance, poor hand and eye coordination, unsteady gait and required one-one caregiver supervision twenty-four hours daily.

Review of an Incident Report dated 04/14/2026 at 10:30 AM showed Resident 1 had become angry and violent towards a caregiver, had thrown an object at them, had punched them, Resident 1 had broken into a cabinet obtaining two kitchen knives and ran after the caregiver while threatening the caregiver with the knives. The incident report showed law enforcement had to respond in order to de-escalate Resident 1 and protect the caregiver.

Review of an Incident Report dated 05/31/2026 at 6:00 PM showed Resident 1 had been outside, unattended by AFH staff, with Resident 2 and a friend, a verbal and physical altercation occurred between Resident 1 and Resident 2, resulting in them hitting one another and Resident 1 biting resident 2, and requiring law enforcement involvement to de-escalate the conflict.

Review of a Behavioral Contract dated 02/27/2026 for Resident 1 stated the resident understood that failing to comply with the expectations of the contract could result in a 30-day eviction notice.

Review of a Behavioral Contract dated 04/20/2026 for Resident 1 stated the resident understood that failing to comply with the expectations of the contract could result in a 30-day eviction notice.

Review of email correspondence dated 06/03/2026 from Collateral Contact 1 (CC1), Behavioral Health Clinician to Collateral Contact 3 (CC3), The Department Case Manager, Collateral Contact 2 (CC2), Behavioral Health Counselor, Staff A, Provider, and Staff C, Acting Care Manager, stated Resident 1 had behaviors associated with the Resident's diagnosis of [REDACTED] and [REDACTED], medications and a reward system for good behavior had been ineffective in the treatment of Resident 1's behaviors and their behaviors continue to escalate. Resident 1 found they can bite and assault people, yell at people, leave and not follow rules, use substances, have repeated trips to the emergency room, because Resident 1 faced no consequences for their actions. CC1 stated that there had been a behavior contract in place, Resident 1 had broken every item in that contract in the last 6 weeks, and the consequence, a 30-day notice of discharge, which was not issued by Staff A. The email further showed CC1 had instructed the AFH to not pick Resident 1 up from the emergency room unless the resident was there for a legitimate health concern, and AFH caregivers continued to retrieve Resident 1 from the emergency room.

On 05/19/2026 at 11:26 AM, Resident 3 stated they had concerns regarding Resident 1's behaviors and had been afraid that Resident 1 could come after them.

On 5/19/2026 at 11:36 AM, Resident 1 stated they had become physically violent towards caregivers in the home, had broken items in the home, and had grabbed knives to keep caregivers away from them. Resident 1 stated they wanted the AFH caregivers to leave them alone.

On 05/19/2026 @ 10:33 AM, Staff B, Caregiver, stated Resident 1 had become violent towards them, threw an object at them, punched them and chased after them with two butcher knives in their hands which they obtained by breaking into a locked kitchen cabinet. Staff B reported that Resident 1 stated they were going to kill Staff B and themselves. Staff B stated they had to flee the home and call law enforcement to intervene and de-escalate Resident 1.

On 5/28/2026 at 10:16 AM, Staff C, Acting Care Manager, stated despite having all of the sharps in the home locked away Resident 1 would manage to break something and use that item as a weapon, Resident 1 had twenty-four hour one on one care in place, and Resident 1's behaviors had been constantly addressed by behavioral health clinicians and the resident's Department Case Manager.

On 05/28/2026 at 11:35 AM, (CC2), stated Resident 1 had a recent escalation in behaviors, a behavioral contract had previously been in place with the consequence being a 30-day notice of discharge, and following the latest incident the provider of the home had wanted to do a second behavioral contract with Resident 1. CC2 stated they had educated the provider about the second behavioral contract, saying the behavior contract would lose the purpose if the terms of the behavior contract were not enacted, and the provider wanted the second behavioral contract in lieu of discharging the resident.

On 05/28/2026 at 12:42 PM, Staff A, stated if Resident 1's behaviors occurred again they would be given a 30-day notice of discharge, and if Resident 1 threatened or put any resident or caregiver in danger Resident 1 could not remain in the home. Staff A stated the home had been staffed with three caregivers and Resident 1 had a one-to-one caregiver twenty-four hours daily due to their behaviors.

On 06/08/2026 at 12:50 PM, Staff C, stated Resident 1 could not be corrected in any way or told they were wrong, as the resident would become angry. Staff C stated Resident 1 believed nothing is ever their fault and takes no accountability. Staff C stated they did not have the tools or authority to address Resident 1's behaviors, they had a discharge notice to be issued to Resident 1, but Staff A instructed (Staff C) not to issue it as Staff A felt it was not the right course of action at the time, and believed Resident 1's behaviors would improve when Staff A returned from vacation on 07/01/2026 (31 days after the incident of aggression on 05/31/2026).

On 06/08/2026 at 1:19 PM, Staff B, stated when Resident 1 and Resident 2 had their conflict, the residents were outside, while Staff B was inside the home preparing dinner. Staff B stated there had only been two staff on duty that day, and the other staff member had to remain upstairs with another resident in the home leaving Staff B the only caregiver for oversight of the residents (including Resident 1) downstairs. Staff B stated on Sundays there had often only been two caregivers, making it not feasible to provide Resident 1 with required one-to-one oversight. Staff B stated when they had attempted to redirect Resident 1's behaviors the resident would react aggressively towards them and not comply. Staff B reported that Resident 1 had been resistant to one-to-one oversight and when oversight was attempted Resident 1 would verbally argue with staff. Staff B stated they did not feel they had the tools to address Resident 1's behaviors due to Resident 1's volatility and rapid escalation to violence when upset.

On 06/08/2026 at 2:03 PM, Resident 2 stated they had a verbal and physical altercation with Resident 1 and Resident 1 had bitten them on their arm.

On 6/8/2026 at 2:16 PM, Staff D, Caregiver, stated Resident 1's behavior had become escalated and violent, they had not felt the home could control Resident 1's behavior. Staff D stated it was just a matter of time before Resident 1 hurt someone.

Statement of Deficiencies

License #: 750767

Compliance Determination #77618

Plan of Correction

CITY VIEW ADULT FAMILY HOME

Completion Date

Page 7 of 7

Licensee: LEAH KAPEEN

07/08/2026

On 06/29/2026 at 10:03 AM, Staff A stated they had not issued a discharge notice to Resident 1 because they had been out of town, wanted to have a police presence when issuing the notice as they feared the resident would damage their property or cause injury to caregivers or other residents in the home.

On 07/06/2026 at 3:58 PM, Staff A stated they had returned home from vacation and had not made any changes or interventions in the home or issued the discharge notice to Resident 1.

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, CITY VIEW ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on
(Date) 8/21/26

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.



Provider (or Representative)

7/24/26
Date

This document was prepared by Residential Care Services for the Locator website.

On 06/29/2026 at 10:03 AM, Staff A stated they had not issued a discharge notice to Resident 1 because they had been out of town, wanted to have a police presence when issuing the notice as they feared the resident would damage their property or cause injury to caregivers or other residents in the home.

On 07/06/2026 at 3:58 PM, Staff A stated they had returned home from vacation and had not made any changes or interventions in the home or issued the discharge notice to Resident 1.

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, CITY VIEW ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on
(Date) _____

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative)

Date